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Some Comments on the Chicago Maternity Center and on the NYC Maternity Center Association

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Judith Walzer Leavitt's paper, Joseph B. Delee and the Practice of Preventive Obstetrics,[1] is a thoughtful retrospective analysis of the work and goals of Dr. DeLee. There are striking similarities and differences between the work of Dr. DeLee through the Chicago Maternity Center and that of the Maternity Center Association (MCA) in New York City.

The MCA Log, 1915–1980,[2] begins with a reference to a 1915 study of facilities for maternity care which was initiated because of the concern of health experts regarding the high rates of infant loss and a general assumption that application of good prenatal and delivery care would reduce the loss.

> "Dr. Haven Emerson, the then Health Commissioner of New York City, named Doctors J. Clifton Edgar, Philip Van Ingen, and Ralph W. Lobenstine a committee to analyze the existing obstetric conditions in Manhattan. . . The findings revealed that approximately thirty-five per cent of the women were delivered in hospitals, thirty per cent by midwives, ten per cent by private physicians with obstetric experience, and the remaining twenty-five per cent by general practitioners. Comparatively few of these patients had any prenatal care. . . The committee report suggested that the city be divided into ten zones for maternity care. . . that a maternity center be established in each of the ten zones:"[2]

MCA, activated as a program of the Women's City Club, developed activities to teach the community about prenatal care, to secure such care for all mothers in the zone, and to conduct a clinic. Founded in 1918, MCA was incorporated as a not-for-profit voluntary health agency with a consumer board of directors; by 1920 there were 30 centers and sub-stations under MCA's supervision.

In 1921, Dublin and Stevens reviewed the records of 8,743 women who had received prenatal and postnatal care under MCA's supervision. They reported "a 29.2% reduction in the deaths of infants less than one month old and a 21.5% reduction in the deaths of mothers as compared with the rates in the city."[2]

In the meantime, Dr. Lobenstine, chairman of MCA's Medical Advisory Board from 1918 to 1931, had been investigating means for improving the work of midwives and, along with Mary Breckinridge, Hazel Corbin, Lillian Hudson, Dr. George W. Kosmak, Dr. John O. Polak, Dr. Benjamin P. Watson, and Dr. Linsly R. Williams, had organized the Association for the Promotion and Standardization of Midwifery. That organization amalgamated with MCA in 1934, and the Lobenstine Clinic and Midwifery School which had been established in 1931 became part of MCA.

Unlike Dr. DeLee, who saw the improvement of maternity care coming through family physicians taking over midwifery practice, MCA focused rather on upgrading and standardizing the work of the midwife. After an attempt in the 1920s to operate a midwifery school for women without particular prerequisite education, the decision had been reached to educate public health nurses in midwifery.

Dr. Leavitt's article[1] on Dr. DeLee's work does not mention commitment to the infant or to mothercraft. In contrast, MCA emphasized the importance of nutrition in both mother and infant health and sent public health nurses to do outreach, tempting the expectant women to the clinic; mothers received a hot lunch and were given layette materials on which they could sew while instruction in infant care was carried out.

In sum, Dr. DeLee and his Chicago Maternity Center and the Maternity Center Association in New York both recognized the value of demonstrating their ideas. Dr. DeLee himself was the agent of change which established and personally supported the Chicago Maternity Center. In New York, the MCA was a voluntary health agency with a strong board of women consumers bolstered by medical advice who effected change and improvement. Both agents saw the value of non-interventionist midwifery. Dr. DeLee saw the practice as an opportunity for family physicians, while the MCA utilized the skills and experience of well-prepared public health nurses to improve the practice directly. Indirectly, through the nurse-midwife's ability to supervise indigenous and immigrant midwives rather than to stamp out their practice, many a newly arrived woman was ensured of care by someone who understood her language and other facets of her culture. This difference in approach is one which is observable even today whenever nurses and physicians problem-solve. The difference need not be looked on as divisive or hierarchical but rather as complementary for the benefit of childbearing families.

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Editor's Note: See also related papers pp 1353 and 1361 this issue.

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